Private Vocational Rehabilitation Specialist Certification Application

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

SEND COMPLETED FORM TO:

DO NOT WRITE IN THIS SPACE

PROVIDER NO:_____

Important Note: All persons who provide private-sector vocational rehabilitation services under the State of Wisconsin's Worker's Compensation Act must be certified by the Worker's Compensation Division prior to providing services to injured workers.

Failure to complete and submit this form for approval may result in non-payment for rehabilitation services provided to injured workers. Changes in qualification status must be reported immediately to the Worker's Compensation Division.

Please Print or Type

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

I. PERSONAL DATA

Applicant Name (Last, First, MI)	Telephone Number ( )	Fax Number ( )
Applicant Business Mailing Address (number, street, city, state and zip code)		
Employer	Telephone Number ( )	Fax Number ( )
Employer Mailing Address (number, street, city, state and zip code):		

II. QUALIFICATIONS

To be certified by the Worker's Compensation Division, you must have a current CRC, CDMS, CVE, State of Wisconsin Professional Counselor license, or comparable qualifications. Attach a copy of your certification.

Certification held: ☐ CRC ☐ CDMS ☐ CVE ☐ WI Professional Counselor License

If you do not have any of the listed certifications, you must submit comparable qualifications with this application.
Also, list 3 professional references below:

(1) _____ _____ (_____)_____
Name Position Telephone No.

(2) _____ _____ (_____)_____
Name Position Telephone No.

(3) _____ _____ (_____)_____
Name Position Telephone No.

(Over)

General Academic Qualifications:

Earned Degree: Major Area: Date Awarded: Institution:

_____

_____

III. EXPERIENCE IN VOCATIONAL REHABILITATION EMPLOYMENT

Employment Data (Current job first. List recent positions involving rehabilitation responsibilities.)
PLEASE DO NOT SEND RESUME.

Employer Name:	Location:
Your Occupation:	From: To:
Employer Name:	Location:
Your Occupation:	From: To:
Employer Name:	Location:
Your Occupation:	From: To:

As a certified specialist, you will provide WC claimants with a full range of re-employment services. Please describe your training and experience in analyzing transferable skills, testing, job placement and retraining plan development.

_____

_____

_____

_____

_____

Identify up to 6 Wisconsin cities where you will provide services: _____

_____

Which Wisconsin counties do these cities represent: _____

_____

IV. APPLICANT AFFIRMATION AND SIGNATURE:

I request certification by the State of Wisconsin Worker's Compensation Division as a private Vocational Rehabilitation Specialist. The information I have provided above is correct and true to the best of my knowledge.

I am now available to provide the necessary services injured workers may need to return to work.

Applicant Signature: _____ Date Signed:_____